TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3130-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…this treatment is necessary to achieve a therapeutic outcome ... This medication is necessary in order to decrease pain, injury related strains, spasms, and to preserve function of the patient."

Amount in Dispute: $269.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "[This claim] is the Texas Star Network… Because this is network healthcare Rule 133.307 does not apply…

The requestor billed for a Medrox Patch, which is a compound of Capsaicin and Menthol. Capsaicin has an 'N' status as a topical. The requestor provided the compound anyway without obtaining preauthorization as required by Rule 134.540."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2015	Prescription Medication (Medrox Patch)	$269.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 defines the terms used for medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.540 sets out the guidelines for use of the closed formulary for claims subject to certified networks.

4. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.
5. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 784 – Service exceeds recommendations of treatment guidelines (ODG)

Issues

1. Does the Division of Workers' Compensation (the Division) have jurisdiction to decide this dispute?
2. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The insurance carrier states that the claim is in the Texas Star Network and indicates that the Division does not have jurisdiction to decide a medical fee dispute. Texas Insurance Code §1305.101 (c) states, "Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, **may not, directly or through a contract, be delivered through a workers' compensation health care network.** Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation" [emphasis added].

   Further, 28 Texas Administrative Code §134.503 (a)(1) states, "This section applies to the reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications as those terms are defined in §134.500 of this title (relating to Definitions) for outpatient use in the Texas workers' compensation system, which includes claims: (A) subject to a certified workers' compensation health care network as defined in §134.500 of this title."

   Review of the submitted documentation indicates that this dispute is related to prescription medication. Therefore, while the claim is part of a certified network, the treatment included in this dispute may not be delivered through a health care network and are subject to the fee guidelines found in 28 Texas Administrative Code §134.503 and the closed formula guidelines found in 28 Texas Administrative Code §134.540.

   28 Texas Administrative Code §133.305 defines a medical fee dispute as, "…A dispute that involves an amount of payment for non-network health care rendered to an injured employee … The dispute is resolved by the division pursuant to division rules, including §133.307 of this title..." Because the services in this dispute are not delivered through a health care network, they are subject to dispute resolution by the Division according to 28 Texas Administrative Code §133.307.

2. The insurance carrier denied disputed services with claim adjustment reason code "784 – Service exceeds recommendations of treatment guidelines (ODG)." 28 Texas Administrative Code §134.540 (b) states, in relevant part, "Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for: … (2) any compound that contains a drug identified with a status of 'N' in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates." Review of the submitted documentation finds that the dispute involves a compound drug that includes the ingredients Methyl Salicylate, Menthol, and Capsaicin. The *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary* in effect on the date of service finds that Capsaicin has an "N" status. Therefore, the compound requires preauthorization.

   28 Texas Administrative Code §134.540 (e)(1) states, "For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug in a specific instance by requesting preauthorization in accordance with the certified network's preauthorization process established pursuant to Chapter 10, Subchapter F of this title (relating to Utilization Review and Retrospective Review) and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing)." Review of the submitted documentation does not

indicate that a preauthorization was requested or obtained. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	June 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.